State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

MAR - 3 2003

To All Interested Parties:

This letter is to provide information about the Department of Health Services' new Title XIX re-verification process for use by hospitals that are undergoing Disproportionate Share Hospital (DSH) audits.

The new Title XIX re-verification process system will be implemented on March 1, 2003. Enclosed you will find a user manual with the background information and new record layout for the system. The new system's record layout is 110 fields in comparison to 55 fields in the previous process.

The new Title XIX re-verification process has been expanded to include name and date of birth matches as well as providing verifications based on Social Security Numbers, Client Index Numbers and Pseudo Social Security Numbers. It is important to note that when you are submitting re-verification for newborns, Medi-Cal eligibility for the newborn is normally based on the mother's Medi-Cal recipient identification number. The newborn can receive the benefits from the mother's Medi-Cal identification number during the month of birth and the following month.

You will receive an aid code when you receive a response code of "2" or "3" and the recipient received benefits under a restricted aid code with a portion of benefits funded by the state-only funds and emergency/pregnancy related services funded by Title XIX.

This new re-verification process is set up to assign each individual company a 4-digit submitter identification number. You must send your identification forms to Ms. Ana Fellines of the Medi-Cal Eligibility in order to receive a submitter identification number. The Department cannot process your files without a submitter identification number.

714 P STREET, ROOM 1692, P.O. BOX 942732, SACRAMENTO, CA 94234-7320
(916) 657-2941
Internet Address: www.dhs.ca.gov

The Department will begin accepting the new record layout on March 1, 2003, and will accept the old record layout until the end of March 31, 2003. Please remember when submitting your files that they must be in zipped files and password protected.

If you have any questions or need more information regarding the systems expansion, please contact Ms. Ana Fellines at (916) 657-1401 or email her at Afelline@dhs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Beth Fife, Chief
Medi-Cal Eligibility Branch

cc: Mr. Dave O'Farrell
Information Technology Services Division
744 P Street, Room 340
Sacramento, CA 95814

Ms. Ana Fellines
Medi-Cal Eligibility Branch
Department of Health Services
714 P Street, Room 1692
P.O. Box 942732
Sacramento, CA 94234-7320

DEPARTMENT OF
HEALTH SERVICES
DHS

Disproportionate Share Hospitals

Eligibility Re-Verification Process User Manual

Information Technology Services Division/
Medi-Cal Application Section
&
Medi-Cal Eligibility Branch

February 2003
Version 1.0

Table of Contents

Purpose of Document

The purpose of this User Manual is to provide a collection of information regarding the Disproportionate Share Hospital (DSH) eligibility re-verification process to all parties participating in the process. This manual includes an overview of the process, detailed instructions for each step of the process and several appendices to provide additional insight.

Overview

Background

DHS has initiated a project to improve the DSH eligibility re-verification process. The two-phased project enhances the matching process as well as supporting administrative processes.

The Disproportionate Share project was initiated to provide better support to the disproportionate share hospitals and their vendors. This project has been split into two phases to allow for quicker implementation of the matching process enhancements. The objective for Phase 1 was to improve the current eligibility re-verification process used by hospitals, their vendors/agents and DHS. Specifically, this phase:

- Expands the search criteria to include name and date of birth
- Automates the matching process to include a DSH database

This manual provides an overview of the improvements to the process completed during Phase 1.

Phase 2 of the project will continue enhancing the matching process as well as improve various administrative aspects of the process. Items being considered for Phase 2 include:

- Expedite the file transfer process by allowing automated transfer of request files (rather than diskettes).
- Create a process to provide CMS auditors (or Medicare Intermediaries) assurances that the re-verification data provided by DHS has not been tampered with by the hospitals or vendors.
- Synchronize the current manual re-verification process (referred to as 'old' in this document) with the new automated.
- Research options for establishing a fee schedule and payment process for recovery of costs associated with providing the re-verification service.
- Ensure all hospitals and/or vendors using the re-verification process have current contracts on file.

Once Phase 2 is implemented, an updated User Manual will be published to all hospitals and vendors participating in the process.

DSH Re-Verification Processing

Re-verification of disproportionate share patient's eligibility status is needed by hospitals to address CMS audits and lawsuits. In some cases, the re-verification requires access to eligibility data no longer available on the Automated Eligibility Verification System (AEVS) or Point of Service (POS) network. As a result, hospitals need the Department's assistance to re-verify patient eligibility against historical data.

Process Overview

Introduction

The DSH eligibility re-verification process relies on a coordinated effort of several parties to ensure timely completion of all steps in the process.

Parties Involved

Processing eligibility re-verification requests from hospitals relies on a coordinated process involving various parties.

The re-verification process involves the following parties:

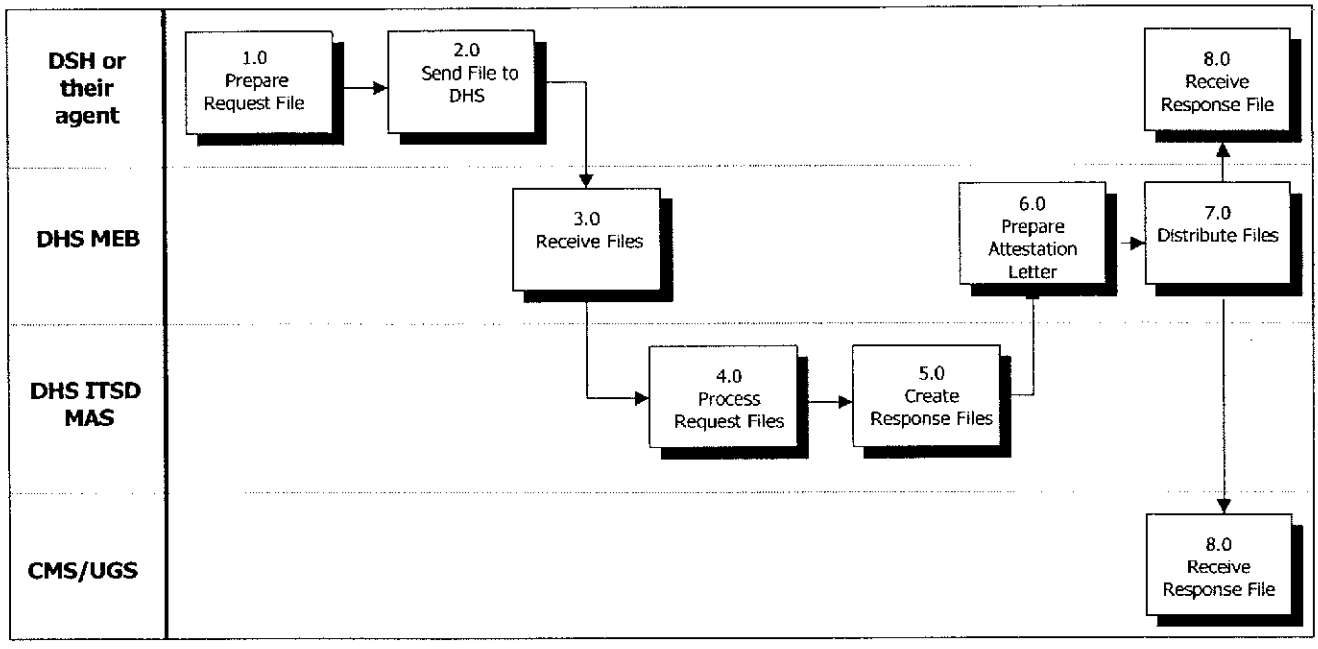
- Submitters are responsible for formatting and creating the inquiry portion of the request record. Submitters include:
  - Disproportionate Share Hospitals (also known as DSH or hospitals)
  - 3rd party vendors (also known as vendors or agents)
- DHS is responsible for receiving and processing all inquiry requests from valid submitters. Within DHS, the following organizational units participate in the process:
  - Medi-Cal Eligibility Branch (MEB) is responsible for receiving all files, ensuring the submitter is valid and setting the overall policies regarding eligibility
  - Information Technology Services Division/Medi-Cal Applications Section (ITSD/MAS) is responsible for processing all requests
- CMS/Medicare Intermediaries (such as UGS) provide advise to MEB on interpretation of disproportionate share rulings

High-Level Overview of Eligibility Re-Verification Process

At the highest level , the eligibility re-verification process includes the following steps:

- The submitter prepares a file of all requests for eligibility re-verification
- The submitter sends the file to DHS
- DHS (MEB) receives the file, logs and reviews the request to ensure the submitter is valid
- DHS (ITSD/MAS) processes the request file
- DHS (ITSD/MAS) prepares a file containing the response data found during processing
- DHS (MEB) prepares the file for distribution and sends to the submitter

A pictorial view representing the process and the parties involved is shown in the following process flow diagram.


DSH or their agent
DHS MEB
DHS ITSD MAS
CMS/UGS
1.0 Prepare Request File
2.0 Send File to DHS
3.0 Receive Files
4.0 Process Request Files
5.0 Create Response Files
6.0 Prepare Attestation Letter
7.0 Distribute Files
8.0 Receive Response File
8.0 Receive Response File

Process – Detailed Description

1.0 Prepare Request File

The hospital or their vendor is responsible for preparing the request file that triggers the eligibility re-verification process.

For hospitals using vendors to create their request files, a letter must be submitted by the hospital to DHS MEB authorizing the vendor to request eligibility information on behalf of the hospital. The letter outlines the specific period of the eligibility request and is only valid for that specific period. A template of the letter is provided in ***Appendix A.***

Step	Action	Tips/Tools
1.1	Submitter determines the appropriate request file format based on the date of service (DOS) that eligibility re-verification is being requested	If the DOS is earlier than 1993 Use the old file format found in ***Appendix C*** If the DOS is within the last 13 months (known as current)  **STOP**, you must use the POS/AEVS process If the DOS is from 1993 forward (less current) Use the new file format found in ***Appendix D***
1.2	Submitter prepares the request file	 Make sure you have a valid submitter ID. To request a submitter ID, refer to the sample letter found in ***Appendix B***  Prepare the file using the appropriate valid values…refer to the specific data dictionary for each file format  The new process allows multiple years to be submitted on one file, unlike the old process that only allows one year per file. Before submitting multiple years on one file, check with your Medicare Intermediary to determine if this is appropriated for your situation

Step	Action	Tips/Tools
		Remember, send only one provider per file
1.3	Submitter secures and prepares file for sending	Make sure the file is secured (such as using PKZIP with password protection) Enclose a transmittal which includes the record count and technical specifications of the file If diskettes are used, the file must be an ASCII text file with CRLF. Only 3 ½ inch diskettes can be processed If a copy is needed for CMS auditors, indicate this in the cover letter accompanying the file

2.0 Send Request File to DHS

The submitter is responsible for sending the file(s) to DHS MEB for processing.

All files submitted MUST be secured to ensure confidentiality of recipient information.

Diskettes should be mailed to:

Ana Fellines
Department of Health Services
Medi-Cal Policy Branch
714 P Street, Room 1692
Sacramento CA 95814

Email submissions should be sent to:

Afelline@dhs.ca.gov

3.0 Receive Request Files

MEB ensures that files are submitted by valid hospitals or vendors.

All request files are received and logged by MEB to ensure the validity of each request for eligibility information.

Step	Action	Tips/Tools
3.1	MEB determines if submitter is contained on the Submitter ID Log	Refer to ***Appendix E***
3.2	For submitters that are vendors, MEB ensures the hospital has provided DHS with an authorization letter	
3.3	MEB enters the submitter ID, name, file name and receipt date into the Tracking Log	Refer to ***Appendix E***
3.4	MEB forwards the file to the ITSD DSH Unit	

4.0 Process Request Files

Files within the current eligibility window WILL NOT be processed by DHS.

The DSH Unit within ITSD MAS is responsible for processing each request file using the correct matching process.

Step	Action	Tips/Tools
4.1	DSH Unit Lead enters the ITSD received date and the name of the assigned staff into the Tracking Log	Refer to ***Appendix E***

Step	Action	Tips/Tools
4.2	The DSH Unit executes the appropriate matching process based on the DOS of inquiry	If the DOS is earlier than 1993 and the record length is 55 Process using the old process If the DOS is within the current 13 months **STOP do not process**, send the file back to MEB If the DOS is from 1993 forward (less current) and the record length is 110 Process using the new process Files created with the old format (record length 55) for DOS after 1993 (the new process) will only be accepted until March 31, 2003

5.0 Create Response Files

Files are prepared using the same media sent by the submitter.

Once processing is completed, the DSH Unit prepares the response file for distribution back to the submitter.

Step	Action	Tips/Tools
5.1	The DSH Unit prepares the response file in the same format received (i.e., diskette)	
5.2	The DSH Unit enters the control totals and processed date from the processing into the Tracking Log	Refer to ***Appendix E***
5.3	The DSH Unit Lead forwards the file to MEB	

6.0 Prepare Attestation Letter

Per CMS, an attestation letter is provided to the submitter.

MEB prepares the Attestation Letter to be sent with the response file back to the submitter. A sample Attestation Letter is provided in ***Appendix G***.

7.0 Distribute Response Files

Upon request, duplicate copies of the response files are sent to the Medicare auditor (such as UGS).

MEB prepares the mailings for sending the files to all appropriate parties.

Step	Action	Tips/Tools
7.1	MEB creates a diskette copy for the CMS auditors, if needed	
7.2	MEB enters the date sent into the Tracking Log	Refer to ***Appendix E***
7.3	MEB sends the files	

8.0 Receive Response File

Phase 2 may include a fee schedule for processing.

The submitter (and possibly the CMS auditor) receive and review their files.

Re-verification and Matching Program

As part of Phase 1, the matching program was enhanced to include a new name/date of birth search in addition to the various ID searches currently available. This section provides an overview of the logic performed by the matching program.

Overview of Program Logic

The matching process uses a newly created Disproportionate Share Hospital Database (DSHDB) for determining eligibility. The DSHDB is an extract of the Monthly Medi-Cal Eligibility File (MMEF). For more information on the DSHDB, refer to ***Appendix H.***

#1 Validate Submitter ID

The input submitter code (Submitter ID field) is examined to determine if it's valid. Invalid entries result in a response code of "9" in the Medi-Cal Eligibility Indicator field. However, since the input submitter ID is used to route the response record to the appropriate submitting entity, the submitter may not receive a response record in these cases.

#2 Edit Date of Service

Next, the match process will edit the inquiry Date of Service (DOS) field for both valid format and inquiry window.

- **Valid Format** – The valid format for the DOS is a numeric year and the month between 01 – 12. If the DOS is not in a valid format, a response code of "6" will be returned in the Medi-Cal Eligibility Indicator field.
- **Valid Inquiry Window** - The valid inquiry window precedes the standard 13-month claims adjudication time period (current and prior 12 months). For example, if the current month of Medi-Cal eligibility is 12/2002, then the inquiry window starts at 11/2001 (2002/12 – 13 months = 2001/11). Eligibility inquiries for dates of service within the last 13 months should be processed via the AEVS or POS network and will not be processed by this program. Inquiries with a DOS that is too recent will result in a response code of "7" in the Medi-Cal Eligibility Indicator field.

#3 Examine Recipient ID

Remember, at least one (1) of three (3) search criteria must be on the request records:

1. *SSN; or*
2. *Medi-Cal ID; or*
3. *First name, last name AND date of birth*

After verifying the DOS, the appropriate database search key will be identified. The following edits attempt to identify the recipient's MEDS ID, which is then combined with the year of service (within the DOS field) and used to read the DSHDB.

- If the Social Security Number (SSN) is present on the inquiry record, then it will be used to read the DSHDB.
- If there's no input SSN, or the input SSN was not found on the DSHDB, then the Medi-Cal ID is examined. If the Medi-Cal ID contains nine (9) characters, and the first character is an "8" or "9" and the last character is a "P", then the Medi-Cal ID is a pseudo MEDS ID and can be used to read the DSHDB.
- If the Medi-Cal ID contains nine (9) characters, and the first character is a "9" and the last character is an alpha (letter) other than

"P", then the Medi-Cal ID is assumed to be a Client Index Number (CIN). The CIN is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.

- If the Medi-Cal ID contains 14 characters, then the Medi-Cal ID is assumed to be a county ID. The county ID is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.
- If no DSHDB record has been found after examining the SSN or Medi-Cal ID, then the name and birth date are cross-referenced to a MEDS ID. The cross-referencing must result in a unique, exact match. If more than one match is found having the exact same name and birth date, but having different MEDS IDs, then a response code of "5" is returned. If a unique exact match is found, then that MEDS ID is used to read the DSHDB.

If none of the recipient identifiers resulted in a record being found on the DSHDB, then a response code of "4" is returned on the response record.

#4 Determine Eligibility

The match process examines four sets of aid codes to determine eligibility.

The month of service (within the DOS field) is used to identify the corresponding month of eligibility on the DSHDB record. The eligible aid codes for that month will be examined to determine if a valid Title XIX aid code exists on the record (the aid codes considered Title XIX are listed in ***Appendix I***). The aid codes on the DSHDB will be examined in the following order:

- Primary Medi-Cal
- Special Program 1
- Special Program 2
- Special Program 3

If an eligible Title XIX aid code is identified, then the share of cost (SOC) indicator is examined. If the SOC indicator indicates an unmet share of cost, then a response code of "2" is returned. If a restricted Title XIX aid code is found during process, it will be returned on the response record for response code "2". If no unmet SOC is indicated, then a response code of "1" is returned.

If there is no aid code found (indicating no eligibility) or, if an aid code is found but it's not within the defined Title XIX aid code list, then a response code of "3" is returned on the response record. In addition, if the aid code is defined as restricted (see ***Appendix I*** for restricted aid codes) it will be returned.

The recipient's Medicare status code for the month of service is examined. If the Medicare status indicates Medicare Part A eligibility, then the

response Medicare Part A indicator is set to "Y" and the Medicare Health Insurance Claim (HIC) number, if present, is moved to the response record.

#5 Create Response Record

Lastly, the response record is written and returned to the submitter with the eligibility response information appended to the original inquiry record. Additionally, once all processing is completed for the submitted file a trailer record (refer to ***Appendix F*** for record format) is produced containing control totals by response code.

Appendices

Appendix A – Hospital Authorization Letter template

<<Submit on Hospital Letterhead>>

<Date>

Mr. Armando Martinez
Department of Health Services (DHS)
714 P Street, Room 1692
Sacramento, CA 95814

Re: Medi-Cal Eligibility Re-Verification for Disproportionate Share (DSH) Determination

Dear Mr. Martinez:

By this letter, <***Full Hospital Legal Name***> (Hospital) has designated <***3rd Party Company Name***> (Agent) as its agent to assist in identifying Medi-Cal eligible patients for purposes of determining our Hospital's disproportionate share for the period of <***Beginning Date***> through <***End Date***>. In exchange for the DHS permitting the Hospital and its Agent to re-verify Medi-Cal eligibility of the hospital's inpatients, the Hospital agrees to do so pursuant to the following terms:

1. Hospital and its Agent shall access Medi-Cal eligibility information on the Hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between Agent and Hospital, the Agent will provide data to the DHS to re-verify the eligibility of those patients who we believe were eligible for Medi-Cal coverage for medical care and services that the Hospital provided.
2. Hospital and its Agent shall use recipient Medi-Cal eligibility information the Hospital obtains for the purpose of the Hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHS.
3. The Hospital or its Agent shall not bring any legal action against DHS that is in any way related to the re-verification of Medi-Cal eligibility.
4. The Agent designated by the Hospital to access Medi-Cal eligibility has a signed agreement with the Hospital agreeing to, among other things, the following terms:

- Be bound by paragraphs 1-3 of this request
- Re-verify eligibility only as a direct result of the Hospital's inquiry on a specific individual
- Adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records
- Not alter any of the recipient information
- Not retain any of the recipient information for anything other than what this agreement for Medicare Disproportionate Share audit

Please contact us if you have any questions regarding this matter.

Sincerely,

<Signature>

<Hospital Officer Name>
<Hospital Officer Title>

Appendix B – Hospital/3rd Party Submitter ID Request Form

<<Submit on Letterhead>>

<Date>

Mr. Armando Martinez
Department of Health Services (DHS)
714 P Street, Room 1692
Sacramento, CA 95814

Re: Request for Submitter ID for Medi-Cal Eligibility Re-Verification for Disproportionate Share (DSH) Determination

Dear Mr. Martinez:

<Full Hospital Legal Name/Company Name> (Submitter) requests a Submitter ID to allow access to Medi-Cal eligibility information to assist in the re-verification of eligible patients for purposes of determining hospital disproportionate share. In exchange for the DHS permitting the Submitter to re-verify Medi-Cal eligibility of our hospital's (or our client's) inpatients, the Submitter agrees to do so pursuant to the following terms:

1. The Submitter (a hospital or its designated agent) shall access Medi-Cal eligibility information on the hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between the agent and hospital, the agent will provide data to the DHS to re-verify the eligibility of those patients who we believe were eligible for Medi-Cal coverage for medical care and services that the hospital provided.
2. The Submitter (a hospital or its designated agent) shall use recipient Medi-Cal eligibility information the hospital obtains for the purpose of the hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHS.
3. The Submitter (the hospital or its designated agent) shall not bring any legal action against DHS that is in any way related to the re-verification of Medi-Cal eligibility.
4. The Submitter agrees to pay for re-verification services once an agreed upon fee schedule is developed by DHS.
5. When the Submitter is an agent designated by the hospital to access Medi-Cal eligibility on their behalf, the Submitter has a signed agreement with the hospital agreeing to, among other things, the following terms:

- Be bound by paragraphs 1-3 of this request
- Re-verify eligibility only as a direct result of the hospital's inquiry on a specific individual
- Adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records
- Not alter any of the recipient information

- Not retain any of the recipient information for any other reason than what this agreement for the Medicare Disproportionate Share audit

Please contact us if you have any questions regarding this matter.

Sincerely,

<Signature>

<Hospital or Company Officer Name>
<Hospital or Company Officer Title>

Appendix C – Old Request Record Format and Data Dictionary

Record Format

Field Name	Start	End	Length
INQUIRY: (filled in by submitter)			
Inout Name	1	23	23
Filler	24	24	1
Inout BID	25	38	14
Filler	39	39	1
Inout MEDS ID SSN	40	48	9
Filler	49	49	1
Inout MOE	50	53	4
Filler	54	54	1
RESPONSE: (filled in by DHS)			
Inout Elig Status	55	55	1

Data Dictionary

Inquiry Portion of the Record – to be filled in by submitter

Field Name: Inout Name

Description:	Beneficiary's (or recipient's) full name
Required/Optional:	Optional
Type:	23 character, alpha
Valid Values/Format:	Left justify name with trailing spaces
Tips:	

Field Name: Inout BID

Description:	Beneficiary ID (BID) or county ID
Required/Optional:	Optional
Type:	14 character
Valid Values/Format:	
Tips:	

Field Name: Inout MEDS ID SSN

Description:	MEDS ID – this can be SSN or MEDS pseudo ID
Required/Optional:	Required
Type:	9 character
Valid Values/Format:	
Tips:	

Field Name: Inout MOE

Description:	Year and month of eligibility for which eligibility status is being requested
Required/Optional:	Required
Type:	4 digit date
Valid Values/Format:	YYMM
Tips:	▪ This file format should only be used for eligibility inquiries prior to 1993 ▪ If eligibility statuses are needed for several months for a beneficiary, multiple records must be submitted, one for each month of eligibility ▪ If date for more than one year is requested, there should be separate diskettes, one for each year

Response Portion of the Record – to be filled in by DHS during processing

Field Name: Inout Elig Status

Description:	Eligibility status code returned during the matching process
Type:	1 character
Valid Values/Format:	Blank – Unprocessed 1 – Medi-Cal eligible for the month of eligibility: For month of eligibility requested, the client was eligible 2 – Not eligible; unmet share of cost; potentially eligible after share of cost is met: Although showing on the Medi-Cal files, the client is not eligible for the periods requested as the record shows they did not meet the share of cost, but potentially eligible if they pay the share of cost 3 – Not eligible, but matched to State eligibility file: the client is not eligible for the period requested, but the client is on the State eligibility file 4 – Not eligible, unmatched to State eligibility file: the client is not eligible for the period requested, the client was not found on the State eligibility file
Tips:	▪ **Do not fill this field** - This field is populated during the DHS matching process.

Appendix D – New Request Record Format and Data Dictionary

Record Format

Field Name	Start	End	Length
INQUIRY: (filled in by submitter)			
File Creation Date	1	8	8
SSN	9	17	9
Medi-Cal ID	18	31	14
Last Name	32	51	20
First Name	52	66	15
Birth Date	67	74	8
Gender	75	75	1
Date of Service (DOS)	76	81	6
Submitter ID	82	85	4
Provider ID	86	94	9
RESPONSE: (filled in by DHS)			
Medi-Cal Eligibility Indicator	95	95	1
Medicare Part A Eligibility Indicator	96	96	1
HIC Number	97	108	12
Title XIX Restricted Aid Code	109	110	2

Data Dictionary

Inquiry Portion of the Record – to be filled in by submitter

Field Name: File Creation Date

Description:	The date the submitter created the request file
Required/Optional:	Required
Type:	8 digit date
Valid Values/Format:	YYYYMMDD
Tips:	

Field Name: SSN

Description:	The nine-digit social security number assigned to the recipient by the Social Security Administration
Required/Optional:	At least 1 search criteria is required (SSN **or** Medi-Cal ID **or** the combination of Last Name, First Name and Date of Birth)
Type:	9 digits
Valid Values/Format:	
Tips:	▪ If field is not used, leave blank – do not zero fill ▪ If there are leading zeros in the SSN, make sure they are included

Field Name: Medi-Cal ID

Description:	The ID associated with the recipient. The ID can be one of the following: ▪ Client Index Number (CIN) assigned by DHS; OR ▪ Pseudo MEDS ID assigned by DHS processing; OR ▪ County ID assigned by the county
Required/Optional:	At least 1 search criteria is required (SSN **or** Medi-Cal ID **or** the combination of Last Name, First Name and Date of Birth)
Type:	9 - 14 character, alphanumeric
Valid Values/Format:	Left justify the number with trailing spaces For Pseudo MEDS ID: Nine (9) characters where the first character is an "8" or "9" and the last character is a "P" For CIN: Nine (9) characters where the first character is a "9" and the last character is an alpha (letter) other than "P" For County ID: Fourteen (14) characters
Tips:	▪ If field is not used, leave blank – do not zero fill ▪ If there are leading zeros in the ID, make sure they are included ▪ Do not use SSN in this field

Field Name: Last Name

Description:	The last name of the recipient
Required/Optional:	At least 1 search criteria is required (SSN **or** Medi-Cal ID **or** the combination of Last Name, First Name and Date of Birth)
Type:	20 character, alpha
Valid Values/Format:	Left justify the last name with trailing spaces
Tips:	▪ For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) ▪ If field is not used, leave blank

Field Name: First Name

Description:	The first name of the recipient
Required/Optional:	At least 1 search criteria is required (SSN **or** Medi-Cal ID **or** the combination of Last Name, First Name and Date of Birth)
Type:	15 character, alpha
Valid Values/Format:	Left justify the first name with trailing spaces
Tips:	▪ For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) ▪ If field is not used, leave blank

Field Name: Birth Date

Description:	The date of birth associated with the recipient
Required/Optional:	At least 1 search criteria is required (SSN **or** Medi-Cal ID **or** the combination of Last Name, First Name and Date of Birth)
Type:	8 digit date
Valid Values/Format:	YYYYMMDD
Tips:	▪ For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) ▪ If field is not used, leave blank

Field Name: Gender

Description:	The gender associated with the recipient
Required/Optional:	Optional
Type:	1 character, alpha
Valid Values/Format:	M = male F = female U = unborn Blank = unknown
Tips:	▪ If the gender is unknown, leave blank ▪ Gender is not used during the matching process

Field Name: Date of Service (DOS)

Description:	The month and year the services were provided, this will be used for determining if the recipient was eligible
Required/Optional:	Required
Type:	6 digit date
Valid Values/Format:	YYYYMM
Tips:	▪ If the date of service spans multiple months, an inquiry record for each month must be created ▪ If the date of service is before 1993, use the record format found in **Appendix C** ▪ If the date of service is within the current 13 months, use the AEVS/POS system for determining eligibility

Field Name: Submitter ID

Description:	The submitter ID associated with your organization, as assigned by MEB
Required/Optional:	Required
Type:	4 digit
Valid Values/Format:	
Tips:	▪ Put leading zeros in the field, for example – if your submitter ID is 1 then the field must appear as "0001"

Field Name: Provider ID

Description:	The provider ID associated with the hospital or clinic providing the service and inquiring about the eligibility of the recipient
Required/Optional:	Optional
Type:	9 characters, alphanumeric
Valid Values/Format:	
Tips:	

Response Portion of the Record – to be filled in by DHS during processing

Field Name: Medi-Cal Eligibility Indicator

Description:	The response code generated during the processing of the matching program
Type:	1 character
Valid Values/Format:	Blank = unprocessed 1 = eligible 2 = potentially eligible with unmet share of cost 3 = matched but ineligible 4 = unmatched 5 = multiple name match 6 = invalid date of service format 7 = invalid date of service, within 13 month billing window 8 = not being used at this time 9 = invalid submitter ID
Tips:	▪ Refer to the **Re-verification and Matching Program** section of the manual for more information on how the response codes are set by the matching program ▪ **Do not fill this field** - This field is populated during the DHS matching process.

Field Name: Medicare Part A Eligibility Indicator

Description:	Indicates whether the recipient is Medicare Part A eligible
Type:	1 character
Valid Values/Format:	Y = eligible for Medicare Part A Blank = not eligible for Medicare Part A
Tips:	▪ **Do not fill this field** - This field is populated during the DHS matching process.

Field Name: HIC Number

Description:	Medicare Health Insurance Claim (HIC) number
Type:	12 characters
Valid Values/Format:	
Tips:	▪ **Do not fill this field** - This field is populated during the DHS matching process.

Field Name: Title XIX Restricted Aid Code

Description:	The restricted aid code found for the recipient during the matching process – the restricted aid code is only returned for response codes 2 and 3
Type:	2 character
Valid Values/Format:	Refer to **Appendix I**
Tips:	▪ **Do not fill this field** - This field is populated during the DHS matching process.

Appendix E – DHS Logs

Submitter ID Log

Used for tracking valid submitters, their assigned Submitter ID and contact information for the organization.

Sub ID	V/H	Organization	Contact Name	Street Address	Mailing Address	City, Street, Zip	Phone	Email
0001	v	ABC Consulting	Joe Smith	567 Bean Street		Beverly Hills, CA 90210	(213) 555-1234	
0002	h	Anytown Memorial Hospital	Ann Jackson	123 Main Street		Anytown, CA 00023	(111) 555-1111	

Tracking Log

Used for tracking all request file submissions to DHS.

Disproportionate Share Inquiry Tracking Log

Sub ID	Submitter Name	Input File Name	Date Received by MEB	Date Received by ITSD	DSH Unit Staff Assigned	Date Processed by ITSD	Total Records on File	Date MEB Sent to Submitter

Appendix F – New Trailer Record Format and Data Dictionary

Record Format

Field Name	Start	End	Length
Response File Creation Date	1	8	8
Record Key	9	17	9
File Record Count	18	26	9
Response Code 1 Count	27	35	9
Response Code 2 Count	36	44	9
Response Code 3 Count	45	53	9
Response Code 4 Count	54	62	9
Response Code 5 Count	63	71	9
Response Code 6 Count	72	80	9
Response Code 7 Count	81	89	9
Response Code 8 Count	90	98	9
Filler	99	106	8
Submitter ID	107	110	4

Data Dictionary

Field Name: Response File Creation Date

Description:	The date the match process was run and the response file was created
Type:	8 digit date
Valid Values/Format:	YYYYMMDD
Tips:	

Field Name: Record Key

Description:	Record key used during final processing
Type:	9 digit
Valid Values/Format:	All nines (999999999)
Tips:	

Field Name: File Record Count

Description:	Total number of records contained on the response file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 1 Count

Description:	Total number of records found to be eligible during processing (response code 1) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 2 Count

Description:	Total number of record with unmet share of cost (response code 2) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 3 Count

Description:	Total number of record found but not eligible (response code 3) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 4 Count

Description:	Total number of records not found during processing (response code 4)
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 5 Count

Description:	Total number of records with multiple names found during the name/date of birth search (response code 5) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 6 Count

Description:	Total number of records with invalid format for date of service (response code 6) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 7 Count

Description:	Total number of records within the current 13 month window (response code 7) on the file
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Response Code 8 Count

Description:	Not used at this time
Type:	9 digit
Valid Values/Format:	Numeric, right justified, zero filled
Tips:	

Field Name: Submitter ID

Description:	The submitter ID associated with your organization, as assigned by MEB
Type:	4 digits
Valid Values/Format:	
Tips:	

Appendix G – Attestation Letter Template

<<On DHS Letterhead>>

<Date>

<Submitter>
<Submitter Address>

Dear *<Submitter Contact Name>*:

This is in response to your Medi-Cal eligibility verification for the *<Hospital Name>* for the fiscal years *<start and end dates>*. We are providing the following Medi-Cal Eligibility Extraction report and the text-file indicating the eligibility status of the records submitted.

The patient records, which were matched to the Disproportionate Share Hospital Database (an extract file created from the Monthly Medi-Cal Eligibility File) and returned with the numeric status codes, mean the following:

"1" Medi-Cal eligible for the month requested.
"2" Not eligible; unmet share of cost, potentially eligible after share of cost is met.
"3" Not eligible; but matched to State eligibility files.
"4" Unmatched to the State eligibility files.
"5" Multiple names matched on State eligibility files – eligible could not be determined.
"6" Date of service was not valid.
"7" Date of service was too current for processing.
"9" Invalid submitter ID – records not processed.

If you have any questions, please contact Ana Fellines of my staff at (916) 657-1401 or you can email her at Afelline@dhs.ca.gov.

Sincerely,

Armando Martinez, Chief
Policy Section B, Unit 3
Medi-Cal Eligibility Branch

Appendix H – DSH Database

The matching program uses the Disproportionate Share Database (DSHDB) to locate the eligibility information for the requested recipient.

Initial Creation and Load

The DSHDB will initially be created from the Monthly Medi-Cal Eligibility File (MMEF) research tapes. The MMEF is the file used for eligibility verification in the existing DSH eligibility verification process. The DSHDB load data will be extracted in six-month intervals, allowing a minimum of six (6) months to a maximum of 12 months of retroactive eligibility reporting to occur. For example, the DSHDB records for the time period 01/1999 through 06/1999 will be created from the January 2000 MMEF file. When fully loaded, the DSHDB will contain historical eligibility data from January 1993 through December 2001.

The DSHDB will contain client demographic data (such as name and birth date) and a table containing monthly eligibility data (such as eligible aid codes, Medicare statuses and unmet share of cost indicators) for each month in the eligibility year. The DSHDB file contains the following fields:

- MEDS ID
- Year of Eligibility
- Starting Month of Eligibility
- Last Name
- First Name
- Middle Initial
- Birth Date
- Gender
- Client Index Number (CIN)
- HIC Number
- Eligibility History Table, containing:
    - Eligibility Aid Code - Primary
    - Eligibility Aid Code – 1st Special
    - Eligibility Aid Code – 2nd Special
    - Eligibility Aid Code – 3rd Special
    - Medicare Status Code
    - Medical Health Care Plan Indicator
    - Unmet Share of Cost Indicator

The DSHDB data is frozen in time and subsequent client demographic updates will not be applied. For example, if recipient Jimmy Smith was known by SSN 111-22-3333 in 1999 and subsequently changed his name and SSN to James Smith, 123-45-6789, in 2001, the DSHDB for 1999 will have Jimmy Smith using SSN 123-45-6789. When the 2001 DSHDB records are created, James Smith, 123-45-6789 will be loaded as a new record. This is being done under the assumption that providers of service will submit their eligibility inquiries based upon patient information as it was on the date of service.

Database Update Process

After the initial load process is completed, the DSHDB will be updated monthly after the MEDS Renewal process has completed, rolling the MEDS system into the new month of eligibility (this happens around the 25th of each month). Using the post-renewal MEDS database backups as input, a DSHDB record will be created containing the 12th prior month of eligibility. These monthly DSHDB updates will be applied to the DSHDB, either adding a new record for the eligibility year or adding a new month of data to an existing DSHDB record.

Appendix I – Aid Code Information

List of Title XIX Aid Codes

OP, OM, ON, 03, 04, 1H, 10, 13, 14, 16, 17, 18, 2A, 20, 23, 24, 26, 27, 28, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 30, 32, 33, 34, 35, 36, 37, 38, 39, 4A, 4C, 4F, 4K, 4G, 4M, 40, 42, 45, 47, 5K 54, 59, 6A, 6C, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, 60, 63, 64, 66, 67, 68, 7A, 7T, 7J, 72, 8E, 8G, 82, 83, 86, 87, 9N

List of Restricted Title XIX Aid Codes

OU, 1U, 3T, 3V, 44, 48, 5J, 5T, 5W, 5X, 5Y, 55, 6U, 69, 7C, 7F, 7G, 7H, 7K, 7N, 74, 76

Narrative Descriptions of All Aid Codes

For a full list of all aid codes used by DHS and their narrative descriptions, refer to the information contained at:
http://www.dhs.ca.gov/mcss/GeneralInfo/Aid_Codes_Documentation.pdf

Appendix J – Contact Information

For more information regarding the DSH process, contact:

Ana Fellines
Department of Health Services
Medi-Cal Policy Branch
714 P. Street, Room 1692
Sacramento, CA 95814

Telephone: (916) 657-1401
Fax: (916) 654-7676

Email: afelline@dhs.ca.gov